Request For Personal Care Services (PCS) Assessment

Personal care services (PCS) is a Medicaid benefit based on the need for assistance with activities of daily living (ADLs). The ADLs are bathing, dressing, toileting, eating and transferring/functional mobility in the home. This for is for requesting a PCS independent assessment. Requested assessments will be one of the following: disenrollment, new request, change of status (medical or non-medical) or change of provider.

Please read the instructions in the sidebar for guidance before completing this form.

Medical change of status or new requests: practitioners only complete pages 1–6.

Request type

Select the type that indicates the reason for the request. Enter the date of request in the appropriate field.

1

Request type (select one):

☐ Change of status: Medical ☐ New request

☐ Managed care disenrollment

Date of request (mm/dd/yyyy) _____

Section A: Beneficiary demographics

The beneficiary's name should be the same as it appears on their Medicaid card. Beneficiaries living in, and those seeking admission to, an adult care home (ACH) will have the facility's address and phone number. If identified as legal guardian or power of attorney (POA), submit guardianship/POA documents to Alliance Health at medicaidpcs@AllianceHealthPlan.org.

2

Beneficiary's name _____

DOB (mm/dd/yyyy) _____

Medicaid ID _____

RSID *(ACH only)* _____ RSID date (mm/dd/yyyy) _____

*The RSID # and RSID Date is generated when a beneficiary being referred or seeking admission to an ACH is referred to a LME-MCO for the RSVP.

Gender ☐ Male ☐ Female

Language ☐ English ☐ Spanish ☐ Other _____

Address

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ ZIP code _____

Phone _____

Alternate contact (select one - should not be a PCS provider)

☐ Parent ☐ Legal guardian (required if beneficiary < 18)

☐ Other relationship to beneficiary (non-PCS provider) _____

Beneficiary's name _____ MID _____

Section A: Beneficiary demographics

Continued

2

Name _____ Phone _____

Active adult protective services case? ☐ Yes ☐ No

Beneficiary currently resides

☐ At home ☐ Adult care home ☐ Hospitalized/medical facility

☐ Skilled nursing facility ☐ Group home ☐ Special care unit (SCU)

☐ Other _____

D/C date (Hospital/SNF) (mm/dd/yyyy) _____

Section B: Beneficiary's conditions that result in need for assistance with ADLS

Enter information regarding current medical conditions that limit the beneficiary's ability to perform, and resulted in a need for assistance with, ADLs. Medical diagnosis and ICD-10 code are both required fields.

3

Identify the current **medical diagnoses related to the beneficiary's need for assistance with** qualifying activities of daily living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the COMPLETE ICD-10 code.

The diagnosis and ICD-10 entered must relate to the ADL deficit for this request to be processed.

Medical diagnosis	ICD-10 code	Impact ADLs	Date of onset (mm/dd/yyyy)
1.		☐ Yes ☐ No	
2.		☐ Yes ☐ No	
3.		☐ Yes ☐ No	
4.		☐ Yes ☐ No	
5.		☐ Yes ☐ No	
6.		☐ Yes ☐ No	
7.		☐ Yes ☐ No	
8.		☐ Yes ☐ No	
9.		☐ Yes ☐ No	
10.		☐ Yes ☐ No	

Beneficiary's name _____ MID _____

Section B: Beneficiary's conditions that result in need for assistance with ADLS

Continued

3

In your clinical judgment, ADL limitations are

☐ Short-term (3 months) ☐ Intermediate (6 months) ☐ Age-appropriate

☐ Expected to resolve or improve (with or without treatment)

☐ Chronic and stable

Is beneficiary medically stable? ☐ Yes ☐ No

Is 24-hour caregiver availability required to ensure beneficiary's safety?

☐ Yes ☐ No

Optional attestation:

This step is optional. Review each statement and initial, only if applicable.

4

Practitioner should review the following and initial only if applicable:

Beneficiary requires an increased level of supervision.	Initial _____
Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction that attacks the brain and results in impaired memory, thinking and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning and the loss of language skills.	Initial _____
Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning and the loss of language skills.	Initial _____
Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior and an increased incidence of falls.	Initial _____

Beneficiary's name _____ MID _____

Section C. Practitioner information

Enter practitioner and practice information in the appropriate field. You may use the practice stamp if applicable. Sign and date once completed.

5 Attesting practitioner's name _____

Practitioner NPI ☐☐☐☐☐☐☐☐☐☐

Select one
- ☐ Beneficiary's primary care practitioner
- ☐ Outpatient specialty practitioner
- ☐ Inpatient practitioner

Practice name _____

NPI ☐☐☐☐☐☐☐☐☐☐

Practice contact name _____

Address

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ ZIP code _____

Phone _____

Fax _____

Date of last visit to practitioner (mm/dd/yyyy) _____

****Note:** Must be < 90 days from received date.

Practice stamp

Signature stamps are not allowed.

Practitioner signature and credentials	Date (mm/dd/yyyy)
x *Type name or print and sign*	

Signature stamp not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Beneficiary's name _____ MID _____

Section D: Change of status: medical. Complete for medical change of status request only.*

Describe the medical change and its impact on the beneficiary's need for hands-on assistance.

This section is required for all medical change of status requests. The date of the beneficiary's last PCP visit must be < 90 days from received date by the IAE.

5 Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance:

Beneficiary's name _____ MID _____

Beneficiary's current provider

It is required that the beneficiary's PCP or inpatient practitioner complete this form. If beneficiary does not have a PCP, the practitioner, currently providing care and treatment for the medical, physical or cognitive condition causing the functional limitation, may complete the form.

6

Agency name _____

Phone _____

Provider NPI ☐☐☐☐☐☐☐☐☐☐

Provider locator code _____

Facility license # (if applicable): _____

Date (mm/dd/yyyy) _____

Physical address

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ ZIP code _____

Beneficiary's name _____ MID _____

Non-medical change of status or change of provider requests, complete pages 7–10 only.

Request type

Select the request type that indicates the reason for the request. Enter the date of request in the appropriate field.

7

Request type (select one):

- ☐ Change of status: non-medical
- ☐ Change of provider

Date of request (mm/dd/yyyy) _____

Beneficiary demographics

The beneficiary's name should be the same as it appears on their Medicaid card. For beneficiaries living in, and those seeking admission to, an ACH, enter the facility's address and phone number.

8

Beneficiary's name _____

DOB (mm/dd/yyyy) _____

Medicaid ID _____

Gender ☐ Male ☐ Female

Language ☐ English ☐ Spanish ☐ Other _____

Address

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ ZIP code _____

Phone _____

Alternate contact (select one should not be a PCS provider)

- ☐ Parent ☐ Legal guardian (required if beneficiary < 18)
- ☐ Other relationship to beneficiary (non-PCS provider) _____

Name _____ Phone _____

Beneficiary currently resides

- ☐ At home ☐ Adult care home ☐ Hospitalized/medical facility
- ☐ Skilled nursing facility ☐ Group home ☐ Special care unit (SCU)
- ☐ Other _____

D/C date (hospital/SNF) (mm/dd/yyyy) _____

Beneficiary's name _____ MID _____

Section F: Change of status: non-medical

Complete if requesting a non-medical change of status. Enter the facility license # and date, if applicable. Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance.

This section is required for all non-medical change of status requests.

9

Requested by (select one):

☐ PCS provider ☐ Beneficiary ☐ Legal guardian

☐ Power of attorney (POA) ☐ Responsible party

☐ Family (relationship) _____

Requester name _____

PCS provider NPI ☐☐☐☐☐☐☐☐☐☐

PCS provider locator code _____

Facility license # (if applicable) _____

Date (mm/dd/yyyy) _____

Contact's name _____

Contact's position _____

Provider phone _____ Provider fax _____

Email _____

Reason for change in condition requiring reassessment (select one)

☐ Change in days of need ☐ Change in caregiver status

☐ Change in beneficiary location affects ability to perform ADLs

☐ Other _____

Describe the specific change in condition and its impact on the beneficiary's need for hands on assistance*:

Beneficiary's name _____ MID _____

Section G: Change of PCS provider

Complete if requesting a change of provider.

10 Requested by (select one):

☐ Care facility ☐ Beneficiary ☐ Other (relationship) _____

Requester's contact name _____

Phone _____

Status of PCS services (select one):

☐ Discharged/transferred
Date (mm/dd/yyyy) _____

☐ Scheduled discharge/transfer
Date (mm/dd/yyyy) _____

☐ No discharge/transfer planned
Continue receiving services until established with a new provider.

Beneficiary's preferred provider

11 Beneficiary's preferred provider (select one):

☑ Home care agency ☐ Family care home ☐ Adult care home

☐ Adult care bed in nursing facility ☐ SLF- 5600a ☐ SLF- 5600c

☐ Special care unit

Agency name TOUCH OF GOLD HOME HEALTH

Phone (980) 428-9668

Provider NPI 1 4 2 7 8 3 5 1 1 5

Provider locator code 003

Facility license # (if applicable): HC7130

Date (mm/dd/yyyy) 01/01/2025

Physical address

Address line 1 2925 E INDEPENDENCE BLVD (Street, P.O. Box, etc.) Address line 2 SUITE 203 (Suite, Building, etc.)

City CHARLOTTE State NC ZIP code 28205

Beneficiary's name _____ MID _____

Submission instructions

Completed request forms should be submitted to Alliance Health via email at medicaidpcs@AllianceHealthPlan.org.

Form submission for PCS:
Email Alliance Health at medicaidpcs@AllianceHealthPlan.org.

Form submission for expedited assessment:
Email Alliance Health at medicaidpcs@AllianceHealthPlan.org.

Questions or expedited assessment process info:
Contact Alliance Health Provider Service Line at 855-759-9700.